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SENATE BILL 2626 By
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HOUSE BILL 2543
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AN ACT to amend Tennessee Code Annotated, Title 4 and Title 56, to improve the process for reconciling disputes, including but not limited to claims disputes, between healthcare providers and healthcare insurers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-226(b), is amended by deleting subdivision (2) in its entirety and by substituting instead the following new language:

(2) If a provider's claim is partially or totally denied in a remittance advice or other appropriate written notice, or a provider's previously allowed claim is subsequently partially or totally denied by a health maintenance organization by an appropriate written notice, then the provider may file a written request to the commissioner to submit the claim's denial to an independent reviewer for review as provided in subdivision (b)(3). In the alternative, the provider may send a written request for reconsideration to the health maintenance organization within sixty (60) days of the receipt of any partial or total denial of the claim. The reconsideration request should include any documentation or information requested by the health maintenance organization. The health maintenance organization must respond to the reconsideration request within sixty (60) days after

receipt of the request. If the health maintenance organization continues to deny the provider's claim or the health maintenance organization does not respond within sixty (60) days of the receipt of the request, then the provider may file a written request with the commissioner to submit the claim's denial to an independent reviewer for review as provided in subdivision (b)(3). The provider must file any request for an independent review within either six (6) months after the health maintenance organization submits a remittance advice or other appropriate written notice denying a claim, six (6) months after the health maintenance organization sends a written notice denying a timely request for reconsideration, or six (6) months after a health maintenance organization sends written notice that the health maintenance organization is seeking to recoup or recover an inappropriately paid claim, whichever date is latest.

SECTION 2. Tennessee Code Annotated, Section 56-32-226(b), is amended by deleting item (A) of subdivision (3) in its entirety and by substituting the following language:

(A) When the commissioner receives a written request for review of a disputed provider claim or claims, the commissioner shall notify, by electronic transmission or otherwise, a representative designated by each health maintenance organization that a written request for review of a claim or claims has been filed. The commissioner shall advise the health maintenance organization of the name and telephone number of the provider submitting the disputed claim or claims, as well as any other information deemed relevant by the commissioner. If, within fifteen (15) days after sending this information to the health maintenance organization, the commissioner is not advised by the health maintenance organization that the disputed claim or claims have been completely resolved, then the commissioner shall refer the claim or claims for review to an independent reviewer on the health maintenance organization's contracted reviewer panel. A provider may request, and the commissioner may allow, the claims of a provider involving the same health maintenance organization to be aggregated together

and submitted for simultaneous review by an independent reviewer. The reviewer shall, within ten (10) working days of receipt of the disputed claim or claims, request in writing that both the provider and the health maintenance organization provide the reviewer any and all information and documentation regarding the disputed claim or claims. The reviewer shall also advise the provider and health maintenance organization to identify all information and documentation that has been submitted by the provider to the health maintenance organization regarding the disputed claim or claims. All requested information or documentation must be received within thirty (30) days of receipt of the reviewer's request or it will not be considered by the reviewer. The reviewer shall then examine all materials submitted and render a decision on the dispute within sixty (60) days of the receipt of the disputed claim or claims, unless either the reviewer requests guidance on a medical issue from the TennCare appeals unit in the department of health, or the reviewer requests and receives an extension of time from the commissioner to resolve the dispute. In reaching a decision, the reviewer shall not consider any information or documentation from the provider that the provider did not submit to the health maintenance organization during that organization's review of the provider's disputed claim or claims. Furthermore, if a provider obtained an authorization from a health maintenance organization to provide services prior to the delivery of these services, (a "prior authorization") then the claim for health care services based on that prior authorization cannot be retroactively denied because the claim was not medically necessary.

SECTION 3. Tennessee Code Annotated, Section 56-32-226(b)(3)(B), is amended by inserting the language "or claims" immediately following the language in the first sentence stating "[s]hould the reviewer need assistance on a medical issue connected with the disputed claim".

SECTION 4. Tennessee Code Annotated, Section 56-32-226(b)(3)(C), is amended by inserting the language “or claims,” immediately following the language “requiring the health maintenance organization to pay any claim”.

SECTION 5. Tennessee Code Annotated, Section 56-32-226(b)(3)(G), is amended by adding the following new language at the end of this subsection:

If a provider fails to make such reimbursement, then the health maintenance organization shall notify the commissioner and the commissioner shall in turn notify the commissioner of health, who shall take appropriate action to suspend the provider’s license to furnish health care services until proper proof is furnished to the commissioner that the provider has reimbursed these amounts to the health maintenance organization.

SECTION 6. Tennessee Code Annotated, Section 56-32-226(b), is amended by deleting subdivision (4) in its entirety and by substituting instead the following new language:

(4) The commissioner shall appoint a panel of five (5) persons, known as the claims processing panel. The panel shall consist of two (2) provider representatives, two (2) representatives of the health maintenance organizations that contract with the state to provide services to the state’s TennCare enrollees, and the commissioner or the commissioner's duly designated representative. The panel shall select a chairperson, and all decisions of the panel shall be made by majority vote of the members of the panel. The panel shall select and identify an appropriate number of independent reviewers to be retained by each health maintenance organization under subdivision (b)(3). The panel shall negotiate the rate of compensation for each reviewer, and the rate of compensation shall be the same for each reviewer. Each health maintenance organization engaged in a TennCare line of business, as a condition of participating in this contract or the TennCare program, shall contract with each reviewer and agree to pay the rate of compensation negotiated by the panel. The members of the panel shall not be paid, but may be reimbursed for travel expenses. All reimbursement for travel

expenses shall be in accordance with the provisions of the comprehensive travel regulations promulgated by the department of finance and administration and approved by the attorney general and reporter. The panel shall meet at least twice each year.

SECTION 7. Tennessee Code Annotated, Section 4-29-227(a), is amended by adding the following new subdivision:

__. Claims Processing Panel, created by Section 56-32-226.

SECTION 8. If any provision of this act, or application thereof, to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 9. The provisions of this act shall take effect upon becoming a law, the public welfare requiring it. The provisions of Section 2 regarding a provider's request to aggregate claims for review by an independent reviewer shall be retroactive for any claims dispute existing on or after October 1, 1999, assuming the filing of the request for independent review is timely.